MFP Stakeholder's Meeting Minutes

December 13, 2007
1pm to 4pm
Pioneer Room, Judicial Wing, ND State Capitol, Bismarck

Documents Provided: Research Design for Money Follows the Person Evaluation, November 20, 2007 Meeting Minutes, Workgroup Membership Listing, and Meeting PowerPoint Slide Show Handout

Attendees:

Advocacy Groups/Consumers:
Helen Funk, ND DHS Aging Services, Ombudsman
Linda Wurtz, AARP
Teresa Larsen, Protection and Advocacy
Bruce Murry, Protection and Advocacy
Judie Lee, IPAT (Rep)
Jim Moench, ND Disabilities Advocates
DeEtt Ruggles, Bowman
Bob Puyear, Bismarck

Housing:
Mike Anderson, Housing Finance

Care Providers:
Barbara Murry, ND Association of Community Facilities
Sharon Klein, Long Term Care Social Workers of North Dakota
Tammy Theurer, ND Association for Home Care
Diane Mortinson, Adult Services Community
Mary Devlin, Cass County Social Services
Custer Health(rep)

Centers for Independent Living:
Royce Schultze, Dakota Center for Independent Living

Department of Human Services
LeeAnn Thiel, Fiscal Liasion
Cherl Wescott, Vocational Rehabilitation
Linda Wright, Aging Services
Karen Tescher, Medical Services
Vicci Pederson, Developmental Disabilities

Tess Frohlich, HCBS, Medical Services
Robin Hendrickson, Developmental Disabilities
Jake Reuter, MFP Grant Manager

Governor's Office:
Tami Wahl

1. Jake Reuter Provided an brief Welcome and Committee Members introduced themselves and their interest in the MFP Grant

2. A review of the Stakeholder Committee's role and responsibilities was provided

3. A listing of Workgroup Membership was provided and reviewed

4. **Mission and Goals Workgroup**

- A summary of the Goals/Benchmarks first meeting was provided to the committee including the proposal to adjust benchmark #1 for Nursing Facility Transitions from 25 to 15 transitions. This recommendation was made as the result of only having six months to transition individuals (June 2008-Decemeber 2008). The recommendation to have all four Centers for Independent Living assist with transitions starting in June of 2008 was also reviewed. Both adjustments were approved by the Committee

- A brief summary of the goals developed by the workgroup were provided including the following goals:
- Develop a process to assist individuals with moving out of institutions and to assure that the get the care that they need
- Develop services that "fill the gaps" in the service delivery system
- Provide services to those persons that would not have naturally moved out of the nursing home
- Transitioning process will identify gaps, identify service needs to address gaps, and develop services that will be used by all populations in need of services-Not just persons from ICF/MRs and NFs

- Produce a culture change

- Education is needed related to:
- Financial planning to meet Long Term Care needs
- Community services available in the Home
- Hospital discharge planners- (available community services)

- Education would help people plan for their future, improve willingness to learn about services options, and accept services in their home

- Question: concerning what was meant by the significant change of implementation of transition statewide right away. Jake explained that this was a decision by the CIL's that they would like to start right away. (Jim Moenech)

- No negative comments from the group concerning the change in numbers and the statewide decision.

- Question: What are the consequences if benchmarks are not met? We will need to justify any differences with CMS before we can get money for the next year. (Cheryl Wescott)

- Sharon asked how people wanting to move out of the nursing home going to be identified. Answer; The MDS, then check to see if they meet the criteria, then looking at notifying the NFTC,

- Barb M.: How are we going to fill in the gaps with services that can't be sustained? A: The grant spirit really is about identifying the gaps and bringing them to the decision makers to point them out.

- Can funds be used to duplicate services for the DD population to allow a transition to occur? We will ask at the February meeting with CMS.

- Bruce: For services for people with DD, are there any caps for services in the waiver? If there aren't caps, but if there is only so much funding for each region, could be an issue.

(LEEANN, WE MAY NEED TO KEEP THIS IN MIND FOR THE BUDGET TO ALLOW FOR MORE FOR COMMUNITY NEEDS.) We need to bring this forward to the legislative session.

5. **Curtis Volesksy, DHS Medical Services:**

Mr. Volesksy provided information related to the medical needy levels for the Committee. Income and Asset Allowances for single and married individuals living in an institution and for those living in the community receiving HCBS services were reviewed. **See Attachment 1**

Bob Puyear said, "This is a sham!" "I mean, $500, come on!" Curtis suggested that people will need to take advantage of other programs, like food stamps and fuel assistance until the medical needy level can be changed. How many legislators live like this? And yet they want their parents and grandparents to live like this?

6. **Goals/Benchmarks workgroup Barriers and Gaps:**

A summary of the barriers/gaps that the workgroup listed included the following:

- Opposition by family members
- Pre-transition payment for services concerns under MFP-No payment for services if person does not move
- CIL coverage areas
- Housing-accessible, affordable, available choices
- Assisted living is not paid an option at this time-no way to pay for the costs at this time
- Rent vouchers normally require long wait
- Current payment/funding source is system based instead of person/needs based process
- Non-medical transportation
- The Medically needy limit of $500 makes living in the community very difficult to afford even with food stamp, fuel assistance, and rental assistance
- Limited community activity-Concerns about isolation
- **BARRIERS IN LAWS, RULES, POLICIES Identified by ADVOCACY GROUPS in April 2007 – See Attachment 2**

    - Mary Devlin said we should add medical transportation to the list.
    - Staffing at all levels is a concern.

7. <u>Dispute Resolution</u>

- Client Assistance Program could be used for dispute resolution. It would probably be better to use the DHS appeals system. It was agreed that MFP would utilize the DHS appeals system.
- Helen Funk commented that before we use the formal appeal process, could look at resolution through the Ombudsman program.

8. <u>Goals and Benchmark Meeting:</u>

- 12/19/07 at 1 to 4 PM at the AARP office

9. <u>Housing:</u>

- Met today, 12-13-07.
- Will work with MIG out of MSU
- Talked about the mechanics of obtaining qualified housing. Need to develop a process.
- Talked about workgroups plan to request each county HAP to give preference to MFP individuals
- January 7th at 10 AM is next meeting

10. <u>Nursing Facility Transitions OP</u>

- Workgroup will meet 1-7-08 and 1-8-08

- Jake has been working with La Rae on developing a role description of what the discharge planner from the NF and the NFTC will do during the transition time. Jake will send this out to the committee members for their review.

- Sharon asked about how HIPAA will come into play when identifying possible transition individuals from the NF. It was agreed that HIPAA issues will need to be addressed.

- Helen Funk said that there are federal guidelines that allow the Ombudsman program to gain access to records if necessary.

- Bob P mentioned that we should be using some of the RCR information when creating this process.

11. <u>Quality</u>

- First meeting will be polycom on 12-17-07.
- 24 hour back up plan will be a real challenge. (May need to build more into the budget for this area.)
- Incident reporting will need to be looked at.

12. <u>ICF/MR Transition OP</u>

- Informal meetings with Developmental Center Staff, Regional DD staff, and State Office DD staff have been held over the last two months. A more formal meeting will be needed when the information gathered is formulated into a draft document.

13. <u>Research Design</u>

A PowerPoint presentation provided by Mathematic Policy Research Inc. explain the research that they will be doing for the MFP Grantee was reviewed and a copy provided to all committee members. This was in response to the question of what evaluations will be completed for the grant that was raised during the 11/20/07 Stakeholder meeting. **See Mathematica PowerPoint related to research design**

- Need to find a vendor to do the Quality of Life surveys. Three surveys will be required for each MFP participant

- The committee requested that a copy of the Quality of Life Survey that will be completed by the research agent Mathematic be E-mail to them.

- Question about how will we see the survey information addressing the natural aging process and how will we use the data collected?

- Bruce: If this is their main experimental design to see if this is effective, seems they don't have a control group. Shelly says they discharge 1100 people a year, it seems this small group wouldn't be very representative.

- Helen Funk says that she is turning poor QSP's over to Adult Protective Services for review. When the Department gets a complaint, they are terminated if there is abuse, neglect, gross neglect. If someone is abusing a client, or not showing up for work, we don't want them on the list to serve anyone. Therefore, they are removed from the QSP list and terminated as a provider.

- Do we as a state want to do more data collection over and above Mathematica? No formal decision was reached at this time.

- Linda W. Could we use the 1100 that are already going home as a control group. Could we do a quality of life survey with those and then do comparisons with the MFP transition group.

- Bruce: In a nursing facility, there is easier access to the nurse. In the community, you have to go to a physician first for care, and that will affect the cost of care for the person that has transitioned.

- Jake asked the group to think about the evaluation piece of the next meeting.

- Teresa suggested that as a selling point for the legislative session, we could video tape an individual that was in the institution and now in their own home and their thoughts on the change.
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14. Interim Final Rule related to Case Management Services:

- Jake talked about the final interim rule that has come out from CMS. This will have an effect on how MFP will work. There was a CMS call at noon. We are currently reviewing and determining how this will affect the Money Follows the Person demonstration grant. Jake will send out copies to group members who request it. Diane Mortenson, Mary Devlin both want a copy.

- Jake did talk about the shorter time period of 180 days versus 60 days. Robbin listened into the call and CMS said MFP will not be held to the same shorter time period because of the different demonstration status.

15. Next Meeting:

- **Jake will review the progress of all the work groups**
- **January 8th from 1 to 4 is the next stakeholder meeting.**
- **Jake will send out the draft of the OP in between January and February meetings for people to review before final submission of the Operational Protocol.**

Attachment 1

Single Recipient

Income and Asset Allowances	Resident in Nursing Facility or ICF-MR	Transitions to Community and Receives HCBS
Personal Needs Allowance	$50	$500 *
Additional Disregard if Live in Community	$0	$20 *
Asset Allowance	$3000	$3000

* Change is effective with month of move.

Recipient with Ineligible Spouse in Community

Income and Asset Allowances	Resident in Nursing Facility or ICF-MR	Transitions to Community and Receives HCBS
Personal Needs Allowance	Recipient: $50 Spouse : $2267	Recipient: $500 * Spouse : $2267
Additional Disregard if Live in Community	Recipient: $0 Spouse : $20 (if aged or disabled)	Couple allowed total of $20
Asset Allowance	Recipient: $3000 Spouse : ½ of countable assets at application. Maximum $101,640 Minimum $20,328	Recipient: $3000 Spouse : ½ of countable assets at application. Maximum $101,640 Minimum $20,328

* Change is effective with month of move.

U:/Curtis/MFP Comparison 11-07

Attachment #2
BARRIERS IN LAWS, RULES, POLICIES Identified by ADVOCACY GROUPS in April 2007

Only the counties provide case management or authorize services for SPED in North Dakota at this time. Others can provide these services if they meet the necessary qualification requirements. The reimbursement for case management services is of concern as many counties are providing additional funding to provide Case Management

This may make it difficult to be able to have an efficacious single point of entry system.

Exempt HCBS providers from equalized rates. (FEDERAL QUESTION) If a home service provider is contacted by someone who lives in a very rural area, and that client would like to pay mileage to have services in their home, it couldn't be done because they are not allowed to charge private pay more than public pay clients.

Home service workers often turn down a client who lives 20 or 30 miles away because they don't get reimbursed for mileage or drive-time. QSP cannot bill for mileage as they are suppose to build mileage into their rates

3. Remove the caps on HCBS. If individuals can only receive services that total less than 960 units per month, it forces them into institutional care. The cap should be the same level as institutional care.

4. We should review the statutes regarding nursing home rates. (NDCC 50-24.4) There is no way to replicate incentive payment for 90% occupancy in the HCBS arena; dividing the allowable historical operating costs by the actual number of resident days (NDCC 50-24.4-10(4) forces the state to pay the overhead for unoccupied beds. Under the funding formula, the State pays overhead to nursing homes for unoccupied beds. There should be a comparable payment for HCBS providers.

5. Address barriers to receiving services in assisted living.

6. Start promoting some of the statutes that would provide stimulation toward meeting Olmstead. Examples:

> **50-24.3-01. Targeted case management.** The department of human services shall establish a targeted case management service for disabled and elderly individuals eligible for benefits under chapter 50-24.1 who are at risk of requiring long-term care services to ensure that an individual is informed of alternatives available to address the individual's long-term care needs.

Funding is limited to Medicaid only individuals

50-24.3-03(5) to identify available non-institutional services to meet the needs of referred individuals.

50-24.3-03(7)

7. To inform referred individuals of the extent to which long-term care services are available, including institutional and community-based services, and of the individual's opportunity to choose, in consultation with an attending physician, family members, and other interested parties, among the appropriate alternatives that may be available.

26.1-45-04.1. Adoption of long-term care benefits comparison guides by commissioner. The insurance commissioner shall adopt rules to create a long-term care benefits comparison guide to be presented at the point of sale between the client and insurance producer. The guide must include information regarding nursing home coverage and alternatives to nursing home coverage.

7. During 2006, DHS established, in administrative code, a cap on personal care services (120 – limited personal care services; 240 – individual is screened eligible for NF or ICF/MR). Institutions do not have a cap on the number of hours provided. The code does not allow for the cap to be waived. The same could be said for an individual looking to get out of an institutional setting. Caps should be eliminated. Money should follow the person.

10. Rate equalization payment method that is in place for nursing facilities. This was established in 1990 and continues to be supported by the NDLTCA.

11. There is continued bias toward institutional care. Institutional care is still a mandated service under Medicaid. Home & community-based services are still optional services. While they are provided in N.D., they are the "alternative". This is based on Federal rules

13. Consider Amends to our State Plan to require and document that before a person can be institutionalized, they must be offered HCBS first.

14. Congress now permits states to set "more stringent" needs-based criteria for NF placements than for HCBS. It maybe more effective to address eligibility for HCBS under the State Plan to allow individuals to receive services earlier. This is allowed by the DRA

15. Congress has mandated independent evaluations and assessments for persons who request HCBS to determine what the person requires. Congress wanted independent evaluations and assessments to prevent "unnecessary or inappropriate care" in the community, but has never required such for institutional care. If this is the case, shouldn't we be asking for independent evaluations and assessments BEFORE persons

are placed into NF's? This would provide for more equality and unnecessary institutionalization.

THE current SPED program (Needs thresholds) limit the services for those that could use the service. Consider for change 16. Independent evaluations and assessments should require the consideration of assistive technology that might help the individual to live more independently.

17. There are less restrictive options for treatment of mental illness than a large institution (NDSH). While it may be barrier that the NDSH is in the State Constitution, options should be explored. Smaller regional or community facilities would be more appropriate and, most likely, eligible to receive Medicaid funds which would save the State money.

18. DHS has a bureaucratic policy that defaults to institutionalization. DHS needs a policy that allows an individual to select HCBS over institutionalization when the individual's physician confirms that the choice is reasonable. DHS should not force individuals to follow the most conservative approach to treatment. There must be room for well-informed, competent, voluntary medical choices.

19. The DHS Plan to Transfer Appropriate Developmental Center Residents to Communities – Report to the Legislative Council includes a recommended action step that requires: "Review and amend where appropriate administrative rules that are a disincentive for Independent Supported Living Arrangement placements." This apparently is recognition that administrative rules are a disincentive for ISLA placements but does not identify any specific rules.

20. The DHS website is not up-to-date for individuals who want to find information online. For example, DHS has a webpage "Publications: Services for People with Disabilities;" it includes links to three Olmstead documents, the newest of which is dated November 2002. The page also links to an undated "Students with disabilities who are transitioning from high school to a job in the community." There needs to be something identifying treatment options, community-based services, residential options, and a balanced description of each. There could be a chart comparing services, regimentation, social opportunities, dining, costs, Medicaid coverage, and flexibility. It should identify places to get more information.

22. Competitive wages for direct support staff in all HCBS services and community DD services are essential for HCBS/DD services to succeed and flourish.

23. Current policies provide too few employment opportunities for people with developmental disabilities. Meaningful employment is a key to self-esteem and successful independent living

24. NDCC 25-01.2(02) entitles people with developmental disabilities to "appropriate treatment, services, and habilitation … in least restrictive appropriate setting".

DHS policy has restricted this to include only those individuals who are eligible for the waiver under Medicaid. Many individuals with DD, who are not MR, are precluded from receiving needed services.

25. “In accordance with [NDAC], when a caretaker is enrolled as a [QSP], respite services cannot be used when the caretaker chooses to be absent from the home due to employment”. This was the response to the following situation:
A 94year-old woman, living in her own home, has lost both of her legs and is dependent on her daughter for care. The daughter gets paid by the State for taking care of her mother. The daughter is not yet old enough to qualify for Medicare so she works 2 days/week to get health insurance coverage for herself. On those 2 days, the State will not pay for a caretaker. The family cannot afford to pay for a caretaker themselves. There are no other family members in the immediate area that can help so a daughter drives over 200 miles, each way, to provide this care 2 days/week.
This was discussed as an issue that would need to be referred to family home care as they would allow for a higher payment. It also shows the need for more flexibility in the system. The state would consider this a “double dipping” situation at this time.

75-03-23-03. Eligibility determination - Authorization of services.

1. The department shall provide written notice to the county social service board of the county where the applicant receives services as of the effective date of the applicant's eligibility for services funded under the SPED program.

2. A person transferred to active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

3. The county social service board's home and community-based services case manager is responsible for:

   a. Verifying that the person transferred to active status continues to meet the eligibility criteria for entry into the SPED program pool;

   b. Developing a care plan; and

   c. Authorizing covered services in accord with department policies and procedures.